Trade Coercion and Addictive Commodities: From Opium Empires to the Cigarette Market-Opening Era

Douglas C. Youvan

doug@youvan.com

www.youvan.ai

December 17, 2025

In the 19th century, Britain's opium commerce with Qing China became a template for a disturbing political economy: when a coveted import drains national wealth, an addictive commodity can be weaponized to reverse the flow, normalize dependency, and consolidate power. This paper examines a modern, legally sanitized analogue: the late-20th-century use of U.S. trade pressure to open or reshape cigarette markets in parts of Asia. The comparison is not a claim that events are identical. Opium was widely illicit in China; cigarettes were legal consumer goods. Yet the structural rhyme matters: state capacity and trade instruments were mobilized to expand access for a product with foreseeable mass mortality, while public costs were externalized across borders and decades. We track the mechanics of "market opening" (tariffs, quotas, distribution, advertising rules), the rhetoric of free trade, and the tension between health sovereignty and commercial leverage. Finally, we confront the hardest quantitative question raised by this history: what does it mean, methodologically and morally, to speak of deaths "from" a nation's cigarettes when brands, licensing, local production, and shifting market shares blur causal attribution? The goal is a disciplined framework for comparison, responsibility, and prevention.

Keywords: opium wars, Qing China, British Empire, East India Company, political economy, addiction commodity, trade coercion, Section 301, USTR, tobacco market liberalization, Asia cigarette markets, advertising and promotion, public health externalities, corporate power, sovereignty, GATT WTO, non-discrimination, mortality attribution, secondhand smoke, counterfactual analysis, ethical accountability.

A collaboration with GPT-5.2-Thinking. 41 pages. CC4.0.

Note: About 25 million deaths worldwide to date attributable to "U.S.-origin" cigarette brands (roughly 1990–2024/25).

Outline

1. Problem Statement and Thesis
1.1 The recurring pattern: trade power applied to addictive demand
1.2 What “analogous” means here: structure, not sameness
1.3 Scope, definitions, and the paper’s central claim

2. The Historical Baseline: Britain, Opium, and Market Enforcement
2.1 The trade-imbalance story and the silver drain logic
2.2 The supply chain: imperial production, private shipping, local distribution
2.3 Illegality, enforcement, and escalation into armed conflict
2.4 The moral vocabulary of the era: commerce, civilization, and harm

3. The Modern Case: Cigarettes and U.S. Trade Leverage in the 1980s–1990s
3.1 Why cigarettes became a strategic export target
3.2 Section 301 as a coercive bargaining instrument
3.3 What “opening a market” meant in practice: tariffs, quotas, retail channels, advertising
3.4 Case sketches: Japan, South Korea, Taiwan, Thailand
3.5 The core tension: domestic antismoking posture vs external commercial push

4. Mechanisms of Harm Expansion
4.1 Price effects, availability effects, and brand competition
4.2 Marketing, identity targeting, and youth uptake risk
4.3 State monopolies vs transnational firms: how control shifts
4.4 Time lag and invisibility: why the casualties arrive “later”

5. The Ethics of Externalized Mortality
5.1 Foreseeability: what was known about tobacco harms and when
5.2 The ethics of leverage: coercion without cannons
5.3 Responsibility layers: state, firm, consumer, regulator
5.4 The “free trade” frame vs the “public health sovereignty” frame

6. Counting the Dead: What Can and Cannot Be Attributed to “U.S. Cigarettes”
6.1 The attribution problem: brand ownership, licensing, local manufacture
6.2 Measuring exposure: market share, consumption intensity, initiation rates
6.3 Translating exposure to mortality: epidemiologic risk models and lags
6.4 A transparent estimation framework with uncertainty bounds
6.5 Ethical use of numbers: avoiding propaganda and false precision

7. Law and Governance: Health Exceptions, Non-Discrimination, and Policy Space
7.1 Trade law basics: the logic of retaliation and compliance
7.2 Health protections under trade regimes: what is permitted, what is contested
7.3 The advertising question: commercial speech vs population health
7.4 The long arc: global tobacco control norms and treaty approaches

8. Lessons and Contemporary Echoes
8.1 The strongest analogies and the decisive differences
8.2 When “market opening” becomes “harm exporting”
8.3 Institutional safeguards: how to prevent coercive expansion of lethal commodities
8.4 A compact test for future cases: product lethality, dependency, leverage, sovereignty

9. Conclusion
9.1 Restating the thesis: the pattern that persists after the particulars change
9.2 What a responsible trade policy would require
9.3 Closing reflection: commerce as power, and power as moral choice

Epilogue: A Numerical Estimate of Deaths From “U.S. Cigarettes” Worldwide

1. Problem Statement and Thesis

The modern world often treats “trade” and “public health” as separate policy rooms: one room talks about tariffs, market access, and growth; the other about mortality, addiction, and prevention. This paper starts from the premise that, for certain commodities, that separation is not descriptive but political. When the traded good is addictive and lethal at population scale, “market access” is not a neutral technical condition. It is a lever over downstream behavior, downstream disease, and downstream death. The paper’s problem statement is simple: when states deploy trade power to expand the circulation of addictive demand, they are not merely moving products. They are moving risk across borders and decades, often in ways that become statistically visible only after the decision-makers have moved on.

The historical touchstone is Britain’s opium commerce with Qing China. The modern analogue explored here is the late-20th-century use of U.S. trade pressure to open or reshape cigarette markets in parts of Asia. The argument is not that cigarettes are opium, or that the U.S. is Britain, or that the 1980s are the 1840s. The argument is that a recognizable pattern persists: trade leverage can be used to reorganize another society’s exposure to an addictive commodity, while the enforcing power captures commercial benefit and disperses the public-health costs.

1.1 The recurring pattern: trade power applied to addictive demand

The recurring pattern is a three-part machine.

First, there is a commodity with a special economic property: it is not merely desirable, but dependency-forming. Once dependency takes hold, demand becomes unusually stable, less elastic, and self-renewing through initiation. This makes the commodity attractive to exporters and unusually difficult for importers to regulate without political conflict. The “consumption” is not simply a preference; it is a pathway that recruits future consumption.

Second, there is an asymmetry of power and an instrument of leverage. In the 19th century, coercion could be military as well as commercial. In the late 20th century, coercion could be bureaucratic and legal: the threat of retaliation, the weight of market size, the ability to punish one sector of an economy to change policy in another. Either way, the practical effect is similar: the weaker side’s policy space shrinks under the pressure of costs it cannot absorb.

Third, there is an externalization of harm that is temporally delayed. With addictive commodities, the main harms are not immediate battlefield casualties but distributed morbidity and mortality unfolding over years: cancers, cardiovascular disease, chronic lung disease, secondhand exposure, and the fiscal burden of healthcare. This time lag is politically useful. It allows the benefits (profits, export growth, “victory” in market access) to be counted quickly, while the costs appear later, in other budgets, in other administrations, in other lives.

When this machine runs, a moral inversion becomes possible: the exporter can speak the language of "free trade" and "consumer choice" while knowingly profiting from a product whose ordinary use kills a significant fraction of long-term users. Meanwhile, the importer's attempt to restrict access can be reframed as "protectionism" rather than public-health defense. The pattern is not confined to opium or cigarettes as substances. It is a governance pattern: leverage applied to normalize exposure, justified as commerce, defended as rights, and paid for in bodies.

1.2 What "analogous" means here: structure, not sameness

The word analogous will do too much work unless it is constrained. This paper uses "analogous" in a structural sense, not a moral or legal equivalence.

Analogous does not mean identical substances, identical legality, or identical motives. Opium in Qing China involved widespread illegality and smuggling dynamics; cigarettes in late-20th-century Asia were legal consumer products. Opium was often framed within imperial extraction and colonial administration; cigarettes were framed within modern trade policy, corporate competition, and regulatory bargaining. One system relied on overt imperial domination; the other could operate through treaties, investigations, retaliatory tariff threats, and institutional trade norms.

Analogous means that the causal architecture rhymes across time:

- A powerful exporter has strong incentives to expand sales of an addictive commodity abroad.
- The importing society has reasons to restrict access (health, social stability, fiscal burden).
- The exporter uses a coercive instrument to reduce the importer's regulatory barriers.
- Market access changes behavior at scale through price, availability, and marketing channels.
- Harm accumulates with delay and is difficult to attribute cleanly to any single actor.

By insisting on structure rather than sameness, the paper avoids two common errors. One error is melodrama: declaring every contested trade dispute an "opium war." The other is sanitization: treating "legal" and "procedural" coercion as ethically inert. The structural approach allows comparison without collapsing distinctions. It also allows us to ask the right diagnostic question: when does trade policy stop being a neutral dispute over tariffs and become a governance act that predictably increases addiction and death?

1.3 Scope, definitions, and the paper's central claim

Scope. The paper focuses on two anchor episodes: Britain's opium commerce into China as the historical baseline and U.S.-linked cigarette market-opening pressures in parts of Asia as the modern case. It does not attempt a comprehensive history of global narcotics, nor a full account of all tobacco industry activity worldwide. It aims instead to build a disciplined comparative frame that can later be used to evaluate other cases.

Key definitions (working). Trade power means the capacity of a state (or bloc) to change another state's policies by imposing or credibly threatening economic costs. Addictive commodity means a good whose consumption can create dependency and whose demand can become self-reinforcing via physiological and behavioral mechanisms. Market opening means policy changes that materially expand access: lowering tariffs, removing quotas, permitting imports, enabling distribution, and allowing marketing practices that intensify uptake. Externalized mortality means deaths and disease burdens that are predictable consequences of expanded consumption but borne primarily by the importing society and by future cohorts.

Central claim. The paper's central claim is that the "opium" story and the "cigarette market-opening" story share a recurring political-economic pattern: trade leverage can be used to expand another society's exposure to an addictive lethal commodity, shifting benefits to exporters and costs to importers, while delay and attribution complexity reduce accountability. The paper further claims that this pattern can be evaluated without collapsing into slogan or propaganda by using a transparent set of criteria: product lethality, dependency strength, leverage intensity, policy-space displacement, marketing/availability change, and foreseeable public-health impact.

In short: this is a paper about how commerce becomes coercion when the good is addiction, and how coercion becomes invisible when the casualties arrive later.

2. The Historical Baseline: Britain, Opium, and Market Enforcement

Britain's opium commerce with Qing China is the clearest "prototype case" for how a powerful trading state can convert a commercial problem into a geopolitical solution by routing it through an addictive commodity. The sequence matters: (1) a stubborn trade imbalance becomes a strategic irritation; (2) a controlled production base supplies a high-margin, dependency-forming good; (3) that good is inserted into a foreign market through gray or illegal channels; (4) when the target state attempts to suppress the trade, the exporter reframes suppression as an offense against commerce itself; (5) coercive force then "enforces market access," and the resulting treaties reshape sovereignty. The opium story is not only about narcotics; it is about the machinery by which commercial desire can be converted into political right.

2.1 The trade-imbalance story and the silver drain logic

For Britain, the central economic pressure point was a persistent asymmetry: Britain (and Europe broadly) strongly desired Chinese goods—tea above all, but also silk and porcelain—while Qing China desired relatively little from Britain in return. The result was a trade pattern that, in practical terms, often required payment in silver. British consumers demanded tea; merchants needed a means of settlement; and China's willingness to accept silver meant Britain's silver outflow became a structural feature of the relationship.

To call this a "silver drain" is not to claim Britain was about to run out of silver, but to name the political psychology of the situation: large, visible outflows of specie feel like national loss, especially when they recur year after year. Trade deficits are tolerable when they are balanced by capital inflows or offsetting exports; they become politically intolerable when the deficit is experienced as tribute paid to a foreign power that refuses reciprocity.

Opium offered an elegant solution to that problem precisely because it reversed the direction of silver flow without requiring China to desire British manufactures. It did not need to "compete" as a normal export. It needed only to be craved. In that sense, opium functioned like an engineered financial instrument: it turned a consumer craving into a settlement mechanism. Once opium demand expanded, silver could move from China outward in payment for the drug, and Britain could use that silver to buy the tea that British households insisted upon. The economic loop closed: opium revenue stabilized tea procurement, and tea procurement stabilized domestic expectation, while the moral cost was displaced across borders.

2.2 The supply chain: imperial production, private shipping, local distribution

The opium economy was not a spontaneous market miracle. It was a carefully structured pipeline that linked colonial administration, agricultural extraction, merchant logistics, and coastal smuggling networks.

At the production end, opium poppy cultivation and processing were centered in British-controlled India, particularly Bengal and surrounding regions. The crucial feature here is not merely "India grew opium," but that British power could organize the conditions of production: land systems, taxation, licensing, processing standards, and the conversion of a plant into a stable export commodity. Even where cultivation involved local farmers, the wider apparatus—who could produce, how it was processed, how it was sold onward—was shaped by imperial governance and monopoly-like controls.

From there, the commodity moved through auction and finance mechanisms that transformed raw opium into commercial lots for merchant purchase. This matters because it created predictable volume, quality, and pricing—enough regularity to scale an illicit trade. The product was then carried by private shipping networks to the China coast and to offshore "floating

warehouses" or distribution points beyond the immediate reach of Qing authorities. The supply chain deliberately sought the boundary zones: places where jurisdiction was ambiguous, enforcement costly, and merchants could bargain from strength.

On the China side, local distribution depended on intermediaries: coastal traders, smugglers, secret societies in some regions, and corruptible officials in others. No empire runs a contraband pipeline without collaborators inside the target society. This is one of the most important structural lessons for later analogies: the exporter does not need to "conquer" the target to reshape demand; it needs reliable internal conduits—economic actors who profit, officials who look away, and consumers who become dependent. Over time, an illicit commodity can build its own constituency: not a moral constituency, but a profit-and-pleasure constituency that resists suppression.

2.3 Illegality, enforcement, and escalation into armed conflict

Unlike later cigarette liberalization, opium importation into China was widely restricted and increasingly prohibited. The Qing state did not merely dislike opium; it treated it as a social and administrative threat. The reasons were layered: addiction undermined households and labor; silver outflows now threatened China's own monetary stability; corruption spread as enforcement officials were bribed; and the drug compromised military readiness and bureaucratic discipline.

Suppression, however, collided with an exporter logic that had become structurally dependent on the opium channel. Once opium revenues were integrated into imperial finance and merchant expectation, enforcement against the trade felt to British commercial interests like expropriation of a "right" they had already internalized: the right to sell what they could profitably sell, and to be protected in doing so.

The escalation pathway typically looks like this: the target state attempts enforcement (seizures, arrests, destruction of stockpiles); the exporter treats enforcement not as domestic regulation but as an injury to foreigners and their property; the exporter demands compensation, apology, or legal guarantees; the target refuses (or offers partial concessions); and coercive force is then introduced under a banner that mixes "national honor," "commerce protection," and "international order."

The resulting wars were not fought only to keep opium flowing, but opium was central to the crisis that triggered them, and the outcomes predictably expanded foreign access and reduced Qing policy autonomy. Treaty arrangements compelled port openings and altered jurisdictional realities in ways that made future enforcement harder. The deeper point is that "market enforcement" became literal enforcement: legal constraints were supplemented by naval

power, and the target state's attempt to protect its population became grounds for punitive action.

Here the baseline pattern becomes visible in its starkest form: an addictive commodity establishes a profitable dependency; the target state tries to break the dependency; the exporter converts the attempt into casus belli; and "commerce" becomes a reason for war.

2.4 The moral vocabulary of the era: commerce, civilization, and harm

The opium episode was morally contested even in its own time, and that contest produced a vocabulary that still echoes in modern disputes—though the words have changed.

One strand of moral language framed the trade in terms of commerce and freedom. Under this frame, "trade" is treated as a civilizational good: it spreads prosperity, connects nations, and disciplines parochial authority. Restrictions become "backwardness," and enforcement becomes "despotism." The drug itself is rhetorically minimized: it becomes a mere commodity, and consumption becomes a matter of choice. This vocabulary is powerful because it converts a specific harmful object into a universal principle. If "free trade" is sacred, then any restriction can be portrayed as immoral regardless of the product.

Another strand framed China through a civilizational hierarchy: the West as modern, rational, and lawful; the Qing state as rigid, humiliating, and unreasonable. This matters because it makes coercion feel like pedagogy. Market opening becomes "teaching a lesson." Violence becomes "necessary correction." The moral weight is transferred from the harm of the commodity to the supposed moral deficiency of the regulator.

Opposing vocabularies also existed: the language of moral injury and social ruin. Missionaries, reformers, and some political critics described opium as a deliberate poisoning of another civilization for profit. Under this frame, the exporter is not a champion of freedom but a trafficker in degradation; and the defense of commerce is a mask for predation. The question becomes blunt: what kind of civilization calls itself civilized while financing itself through addiction?

What makes the baseline so useful for comparison is not that it yields an easy moral verdict (though many find it does), but that it reveals the rhetorical moves that recur later: universalizing commerce, minimizing harm, moralizing the regulator as irrational, and treating the exporter's interests as an extension of national dignity. In later cases, the words shift from "civilization" to "rules-based order," from "honor" to "credibility," from "commerce" to "market access." But the underlying moral maneuver—turning a harmful commodity into a principle and a principle into a weapon—remains recognizably the same.

3. The Modern Case: Cigarettes and U.S. Trade Leverage in the 1980s–1990s

The late-20th-century cigarette episodes are valuable precisely because they are "modern" in form. There are no gunboats in harbor, no formal declarations of war, and no open admission that the target is addiction. Instead, there is a familiar contemporary grammar: market access, non-discrimination, rules, retaliation, compliance. Yet when the commodity is cigarettes, the underlying question is unavoidable: what does it mean to apply state trade power to expand another society's exposure to a product that is lethal at scale when used as intended?

This section treats the U.S.-linked market-opening push as a governance case study. The point is not to claim that trade officials set out to "export death." The point is that, when the product is inherently harmful and dependence-forming, "market opening" is not value-neutral. It predictably reshapes consumption pathways, especially through price, availability, and marketing.

3.1 Why cigarettes became a strategic export target

Cigarettes became a strategic export target because the industry's underlying economics were colliding with domestic limits. In high-income countries, smoking rates were declining under the weight of accumulating medical evidence, public health campaigns, restrictions on advertising, rising taxes, and litigation risk. For large cigarette firms, this created a growth problem: how do you sustain shareholder returns when your home market is saturated or shrinking?

International expansion offered a clean answer. Many middle-income countries had rising incomes, youthful demographics, and less mature tobacco-control regimes. Even where state monopolies controlled production and sale, the sheer size of the consumer base made these markets attractive. The prize was not just volume. It was brand positioning: once a premium foreign brand gains cultural prestige, it can sustain higher margins and lock in loyalty among new cohorts of smokers.

Cigarettes also have logistical advantages as an export good. They are compact, high value per unit weight, relatively stable in storage and shipping, and easy to distribute once retail channels are accessible. They are "repeat purchase" goods, and dependence makes demand unusually durable. From a corporate planning perspective, that combination is hard to resist: predictable revenue, scalable marketing, and a product that recruits its own future customers through initiation.

Finally, the structure of many Asian cigarette markets made them appear to trade strategists as "textbook barriers." When an economy limits imports through high tariffs, quotas, licensing restrictions, or state monopoly control, it creates a policy surface that can be challenged as discriminatory or protectionist. That is the hinge: cigarettes were not only profitable; they were also plausibly litigable as a trade issue.

3.2 Section 301 as a coercive bargaining instrument

Section 301 functioned as coercive bargaining because it allowed trade conflict to be converted into credible threat. The classic mechanism is simple: if a foreign market blocks U.S. exports in ways the U.S. deems unfair, the USTR can investigate and, if negotiations fail, recommend retaliatory measures. The retaliation need not target the offending sector. It can be aimed at politically sensitive exports, creating domestic pressure inside the target country to concede.

This is coercion without cannons: the capacity to impose concentrated economic pain, quickly, on a chosen slice of the target economy. For the target state, the problem becomes one of political triage. Even if it believes its restrictions are justified on health grounds, it must weigh those health arguments against the immediate risk of broader trade penalties that may harm unrelated industries and workers.

Section 301 also concentrates decision-making. A trade dispute can move from a diffuse policy disagreement into a formal process with deadlines, leverage points, and escalating consequences. That procedural structure can favor the party with the greater tolerance for conflict and the larger market. When the U.S. market is immense, denial of access or retaliatory tariffs become powerful tools.

The deeper governance feature is that Section 301 can treat health-protective regulation as a "barrier" unless it is framed in a way that fits trade norms. In other words, the target may be pushed not only to permit imports, but to redesign its regulatory architecture to satisfy standards of non-discrimination and least-trade-restrictive alternatives. That is where "trade" becomes a constraint on the shape of public health policy.

3.3 What "opening a market" meant in practice: tariffs, quotas, retail channels, advertising

"Opening a market" was not a single switch. It was a package of policy changes that, taken together, shifted a market from protected and controlled to contested and promotable.

Tariffs matter because they affect price. Lower tariffs tend to reduce the retail price of imported cigarettes or at least reduce the price premium that protects domestic brands. Even modest price changes can affect initiation and consumption intensity, especially among youth and lower-income groups. When a harmful product becomes cheaper relative to income, the public health burden tends to rise over time.

Quotas and import licensing matter because they determine availability. A quota turns imports into a controlled trickle; removing it turns imports into a scalable supply. Licensing rules can be used to block distribution quietly without formally banning the product. "Opening" often meant dismantling these quiet constraints and allowing imports to enter through ordinary commercial channels.

Retail channels matter because distribution is destiny. If imported brands are confined to a narrow set of outlets, they remain niche and socially bounded. If they can enter convenience stores, supermarkets, and ubiquitous kiosks, they become ambient. Ambient availability is a powerful behavioral factor: it normalizes the product, increases impulse purchases, and makes initiation easier.

Advertising and promotion matter because cigarettes are not just a pharmacological product; they are an identity product. Marketing can attach smoking to modernity, glamour, rebellion, adulthood, thinness, sophistication, or Western cosmopolitan status. When advertising channels open, the change is not merely informational. It is cultural engineering that can reshape gender norms around smoking, youth experimentation, and social permission structures.

So "opening" often meant more than admitting imports. It meant enabling the full commercial system that makes a consumer product grow: legal access, price competitiveness, wide retail presence, and the ability to build brand meaning through promotion.

3.4 Case sketches: Japan, South Korea, Taiwan, Thailand

Japan illustrates a high-visibility pathway: a mature economy with strong domestic structures and a prominent state role in the tobacco sector. "Opening" in such a setting tends to involve disputes over tariffs and differential treatment, with negotiations that emphasize non-discrimination and equal commercial footing. Once imported brands are no longer structurally disadvantaged, competitive dynamics can shift quickly, especially when foreign brands carry prestige and strong marketing capacity.

South Korea represents a case where rapid modernization, changing consumer culture, and evolving regulatory frameworks created a fertile environment for brand competition once restrictions loosened. In such contexts, market-opening pressure interacts with cultural transition: imported goods can symbolize modernity, and cigarettes can become a vehicle for that symbolism. The public health stakes are amplified when youth cohorts are large and when social norms around consumption are in flux.

Taiwan is often discussed as a case where market access expanded quickly under trade pressure, with negotiated terms that affected both import conditions and the promotional environment. It is a useful example because it highlights the difference between "legal importation" and "commercial expansion." When promotional channels are part of the settlement, the agreement is not merely about trade volumes; it is about permission to shape demand.

Thailand is the most conceptually clarifying case because it forces the collision between trade rules and health sovereignty into the open. The Thai approach, at points, leaned toward

prohibition or near-prohibition of imports. The trade challenge then posed a question that later became foundational in trade-and-health disputes: can a country protect public health without discriminating against foreign products, and without using measures that trade adjudicators consider more restrictive than necessary? Thailand's case is instructive because it shows how a country can be told, in effect: you may regulate strongly, but you must do so in a form that fits trade architecture. That requirement can still preserve health goals in theory, but it narrows the available policy moves and can increase the administrative burden of enforcement.

Across these cases, the common feature is not identical policy text. It is the functional outcome: restrictions that kept foreign cigarettes expensive, scarce, or hard to promote were weakened, and the commercial system for competitive brand growth gained space to operate.

3.5 The core tension: domestic antismoking posture vs external commercial push

The core tension is not subtle. Domestically, the U.S. increasingly treated smoking as a major public health threat. The public narrative emphasized prevention, warnings, cessation, restrictions on advertising, smoke-free spaces, and the reduction of youth initiation. Even without specifying any single year, the moral posture is clear: smoking is dangerous, and policy should reduce it.

Externally, trade policy sometimes acted as if cigarettes were an ordinary good whose market access deserved state advocacy. That creates a two-level ethics problem.

At the first level, there is a credibility problem: how can a government justify strong domestic discouragement while using its international leverage to increase access abroad? Even if the trade rationale is framed as neutral enforcement of non-discrimination, the outcome predictably expands consumption pathways elsewhere.

At the second level, there is a responsibility problem: trade policy is not just description; it is intervention. When a state pushes open a market for a lethal commodity, it participates in the causal chain that increases disease burden, even if indirectly, even if the harms arrive later, even if responsibility is shared among many actors. The moral question is not whether the target society has agency. Of course it does. The moral question is whether it is legitimate to apply coercive economic tools to narrow another society's ability to resist the expansion of a harmful addictive product.

This tension is the modern heart of the analogy. In the opium baseline, coercion was overt and the commodity's social damage was widely recognized. In the cigarette cases, coercion was procedural and the commodity's damage was also well understood, but the language of trade allowed the conflict to be framed as technical rather than moral. The result is a pattern that can reproduce itself quietly: harm exports can be executed as "policy," defended as "rules," and

remembered as “trade history,” while the public health consequences accumulate as an unassigned debt.

4. Mechanisms of Harm Expansion

When an addictive commodity moves from a protected, constrained market into an open, competitive, marketing-enabled market, the harm does not expand by magic. It expands through ordinary economic and social mechanisms that become unusually potent because nicotine dependence converts experimentation into repetition, and repetition into long-run disease risk. This section isolates those mechanisms. The point is not to moralize “markets” in the abstract, but to show how specific policy changes (tariffs, quotas, distribution permissions, advertising rules) translate into predictable changes in initiation, intensity, and ultimately mortality. Once the pathways are clear, the ethical stakes become clearer too: a trade dispute about “access” is also a dispute about which levers of harm are allowed to move.

4.1 Price effects, availability effects, and brand competition

Price is the most direct lever on consumption, and it matters at two distinct stages: initiation and persistence.

At the initiation stage, the relevant population is not “adult smokers” but potential smokers—often adolescents and young adults—who are price sensitive because their disposable income is limited and their smoking is exploratory rather than habitual. Lower prices reduce the immediate friction that prevents experimentation from becoming routine. Tariff reductions, relaxed import barriers, and intensified competition can all push prices down or at least reduce the premium that limits access to certain brands. Even where retail prices do not fall dramatically, the appearance of frequent discounts, promotions, or cheaper brand tiers changes perceived affordability and normalizes purchase behavior.

At the persistence stage, once dependence takes hold, price sensitivity is reduced but not eliminated. Smokers adjust through brand switching, reduced consumption, or shifts to cheaper products. Competitive markets provide more options for those adjustments, which can keep consumption going even when taxes rise or incomes fall. In a protected market with limited brand variety, price increases may more effectively suppress consumption; in a competitive market, consumers can “shop the addiction” down the price ladder rather than quit.

Availability is the second lever. It is not just whether cigarettes can enter the country, but whether they can become omnipresent. The difference between restricted distribution and ubiquitous retail presence is behavioral, not merely logistical. Ubiquity makes cigarettes part of the landscape of daily life: at the convenience store counter, at transit kiosks, at small shops, in

nightlife districts. Ubiquity reduces the effort needed to sustain consumption and increases the number of “cue moments” that trigger craving. When dependence exists, cues matter; and availability is a continuous cue.

Brand competition then amplifies both price and availability effects. Competition drives distribution reach and retail placement. It also drives product segmentation: premium brands for status, value brands for price-sensitive consumers, slim or “light” variants marketed as refined or less harmful, menthol variants for sensory appeal and smoother initiation. Competition is not simply a fight for market share; it is a mechanism for expanding the market by recruiting new users and retaining existing ones under shifting economic conditions.

The combined effect is straightforward: lower barriers and stronger competition tend to increase the ease of starting and the ease of continuing. With addictive goods, “ease” is not a neutral improvement in consumer welfare; it is a structural expansion of harm capacity.

4.2 Marketing, identity targeting, and youth uptake risk

Marketing is where cigarettes behave less like a commodity and more like a social technology. Nicotine creates dependence, but marketing creates permission. It supplies narratives that help a potential smoker answer the question, “What does this make me?”

Identity targeting works by attaching smoking to desired self-concepts and desired group membership. In rapidly modernizing societies, imported brands can be marketed as cosmopolitan, sophisticated, adult, Western, liberated, or elite. This is not an incidental aesthetic. It is a behavioral funnel. If smoking can be framed as participation in modernity, then smoking becomes a rite rather than a habit. It recruits people who are not “seeking nicotine” but seeking a symbol.

Gender targeting is a particularly potent form of identity marketing. In many societies, female smoking rates were historically low due to stigma and social norms. For an industry seeking growth, that low baseline represents a “frontier.” Marketing can reframe smoking for women as emancipation, slimness, glamour, professional adulthood, or defiance of tradition. The public health consequence is not simply more smokers; it is the intentional re-engineering of a cultural barrier that previously limited harm.

Youth uptake risk is the central issue because most long-run tobacco mortality is downstream of early initiation. The earlier the initiation, the longer the exposure window, the stronger the dependence, and the harder cessation becomes. Youth are also uniquely vulnerable to marketing cues because identity formation is underway, peer status matters intensely, and risk appraisal is developmentally incomplete. Marketing that is not explicitly “for youth” can still function as youth recruitment by saturating the environment with aspirational imagery.

Sponsorships, point-of-sale displays, product design, and lifestyle association often do more work than explicit youth-directed ads.

Advertising restrictions, where they exist, often create a cat-and-mouse dynamic. When one channel closes, marketing shifts to another: retail placement, event sponsorship, indirect branding, packaging design, and "brand stretching" into adjacent products. This is one reason why "opening" a market by permitting broad promotion is qualitatively different from merely allowing imports. Promotion is the mechanism that makes cigarettes culturally scalable.

With cigarettes, marketing is also a form of epistemic manipulation. The industry has historically exploited ambiguity, introduced misleading descriptors, and emphasized "choice" while downplaying addiction. Even without making claims about any single campaign, the general logic is stable: marketing converts a lethal product into a lifestyle accessory, and lifestyle is how many people first encounter the product.

4.3 State monopolies vs transnational firms: how control shifts

Many countries historically managed tobacco through state monopolies or heavily regulated domestic industries. This arrangement can be morally ambiguous—states profit from tobacco too—but it changes the control dynamics. A monopoly can, at least in principle, restrict advertising, limit product variety, keep distribution bounded, and align pricing with public revenue goals. The state becomes the central node through which control can be imposed, and it can be pressured by domestic public health advocates.

When transnational firms enter or expand, control becomes more fragmented and more resistant to unified regulation. Transnational firms have specialized marketing expertise, global brand portfolios, lobbying capacity, and legal resources. They can pressure regulators through trade arguments, investment threats, or litigation. They can negotiate from a position of mobility: production can move, capital can move, sponsorship budgets can move. Regulators cannot.

The shift also changes the state's incentives. A state monopoly earns revenue directly and may be tempted to promote consumption for fiscal reasons, but it is also accountable domestically for public health costs and can, under public pressure, impose constraints without facing "foreign investor" retaliation. When foreign firms gain market share, the state may still collect taxes, but a significant portion of profits flows outward, while the health costs remain internal. This is a crucial mechanism of externalization: the fiscal and political benefits of consumption become partially external, while the burdens remain local.

Competition between a state monopoly and transnational firms can also drive a "race to commercial intensity." The monopoly, if it seeks to retain market share, may adopt more aggressive marketing practices. The regulatory environment can become more permissive not

because the state wants more smoking, but because it is defending the competitiveness of its own enterprise or responding to the political influence of newly empowered commercial actors.

In this way, market opening is not merely an addition of imported cigarettes. It is a reconfiguration of governance: from centralized control (however flawed) to a multi-actor market in which control is contested, costly, and often diluted.

4.4 Time lag and invisibility: why the casualties arrive "later"

The most politically decisive feature of tobacco harm is temporal delay. The causal chain is slow enough to be denied, and fast enough to be catastrophic.

At the individual level, many smoking-related diseases have long latency periods. A teenager who starts smoking at 15 may not experience severe consequences until middle age, and even then the path to diagnosis is gradual. This delay allows the early years of smoking to be experienced as "harmless" or "manageable," reinforcing the illusion that warnings are exaggerated. It also means that policy choices that increase initiation rates do not produce immediate visible piles of bodies. They produce statistics decades later.

At the population level, the delay has two effects. First, it breaks accountability. The officials who pushed market access, the negotiators who signed agreements, and the executives who launched campaigns can all plausibly say: "Those deaths are not in my term, not in my ledger, not in my jurisdiction." Second, it makes the harm legible only through epidemiology and actuarial accounting. You do not "see" the deaths as a single event; you infer them as excess mortality, reduced life expectancy, and elevated disease prevalence.

Invisibility is compounded by attribution complexity. Smokers die of lung cancer, heart disease, stroke, COPD, and other conditions that also occur in non-smokers. The causal link is statistical and probabilistic rather than singular and cinematic. This makes it easy for opponents of regulation to insist on uncertainty and for beneficiaries of sales to insist on personal responsibility. "He chose to smoke" becomes a moral shield, even when the system was engineered to recruit him at 16 and keep him smoking at 36.

Time lag also interacts with the rhetoric of trade. Trade disputes are decided on short timelines: investigations, negotiations, sanctions, compliance. The outcomes can be measured in import volumes, market share, and revenues within a year or two. The health costs unfold over decades. That mismatch creates a structural bias: policy systems are built to count the benefits and ignore the harms because the harms do not fit the accounting window.

This is why the analogy to opium is more than rhetorical flourish. Opium and tobacco differ in legality and context, but they share the same advantage for the exporter: harm that is delayed, dispersed, and therefore politically easy to discount. When casualties arrive "later," they arrive

as background noise rather than a scandal, as chronic burden rather than emergency. And chronic burden is the easiest kind of tragedy for power to tolerate.

In sum, harm expansion is not an accident of culture. It is the predictable output of policy levers—price, availability, marketing, control structure—operating on an addictive product within a system that counts commercial wins quickly and counts deaths slowly.

5. The Ethics of Externalized Mortality

The moral question at the center of this paper can be stated without rhetoric: what does it mean to use state power to enlarge the circulation of a commodity that is predictably lethal at population scale, when the resulting deaths are borne elsewhere and later? “Externalized mortality” names a specific pattern of harm distribution: the benefits of expanded sales accrue quickly to exporters (and often to corporate balance sheets), while the costs materialize slowly as disease, disability, healthcare burden, and premature death within the importing society. The ethical tension is not resolved by pointing to legality, nor by pointing to consumer choice. Legality can coexist with moral wrong, and choice can be engineered, constrained, and impaired by dependence.

This section treats the cigarette market-opening era as a case of governance ethics: a conflict between commercial leverage and health sovereignty, under conditions where the harms were foreseeable, the leverage was asymmetric, and accountability was diluted by time lags and shared causality.

5.1 Foreseeability: what was known about tobacco harms and when

Ethically, foreseeability matters because it is the bridge between “bad outcomes happened” and “someone is responsible for choosing a pathway that predictably produced them.” For tobacco, the crucial point is that, by the late 20th century, the causal relationship between smoking and major disease categories was not speculative. It had become part of mainstream medical and public discourse in many countries. Even if one avoids disputing precise dates, the broad shape is stable: the health risks were widely recognized well before the trade confrontations of the 1980s–1990s reached their peak.

Foreseeability also includes two additional layers beyond “smoking is harmful.”

First, dependence was understood as a central feature, not an incidental side effect. That matters because dependence changes the moral status of “choice.” A product that predictably diminishes the user’s future freedom to stop using it is not ethically equivalent to a product that merely satisfies a preference. The moral landscape shifts when the product recruits repeat behavior through pharmacological capture.

Second, the social epidemiology of initiation was increasingly clear: most long-run tobacco mortality is downstream of early uptake, and early uptake is shaped by price, availability, and marketing environment. This means that policies that expand distribution and promotion do not merely "serve existing smokers." They tend to enlarge the cohort of future smokers. The predictable consequence is not merely a reallocation of brand share, but a change in population exposure.

So the ethical baseline for the modern case is not ignorance. The baseline is: actors were operating in a world where tobacco's lethality, dependence, and recruitment dynamics were sufficiently known that expanding market access could reasonably be expected to increase long-horizon disease burden.

5.2 The ethics of leverage: coercion without cannons

The phrase "coercion without cannons" points to a modern moral problem: a state can compel policy change in another state without firing a shot, by threatening economic penalties that the weaker party cannot reasonably absorb. This raises a question of legitimacy: when does trade bargaining become coercion, and when does coercion become ethically equivalent to forms of force we would readily condemn?

A useful ethical test is voluntariness under credible threat. If a target state "agrees" to policy changes primarily to avoid broader retaliation—especially retaliation aimed at unrelated sectors—then consent is compromised. The agreement may still be legally valid, but ethically it resembles an ultimatum rather than a mutual bargain. The asymmetry is the substance: one side can endure escalation; the other cannot.

This is not an argument that trade leverage is always immoral. States bargain hard all the time, and retaliation is part of how trade systems enforce commitments. The ethical concern arises when the object of leverage is not a neutral product category but a commodity with mass-mortality implications, and when the leverage specifically narrows the target's capacity to protect health. In such cases, the "price" of compliance is not merely economic adjustment; it is increased exposure of future cohorts to addiction and disease.

The moral gravity increases when leverage operates across moral domains. If a threat aimed at, say, auto exports is used to force concessions in tobacco policy, the coercion is structurally insulated from democratic debate about health. Citizens who might accept trade concessions in one sector may not accept increased permissiveness for a lethal commodity—but the linkage created by leverage bypasses that deliberation. This is how coercion becomes ethically invisible: it is executed through procedural channels that feel technical, while the harm it enables is biological and slow.

5.3 Responsibility layers: state, firm, consumer, regulator

One reason externalized mortality persists is that responsibility is easy to disperse. Each actor can name a true fragment of the causal story and treat it as exculpatory.

The consumer chose to smoke. The firm sold a legal product. The state enforced trade rules. The regulator could have taxed more, restricted ads more, educated more. All of these can be true, and yet none of them dissolves responsibility. The ethical task is to assign responsibility in layers without pretending it is zero-sum.

A helpful distinction is between proximate agency and structural agency. Consumers are proximate agents: they light the cigarette. But structural agents shape the environment in which that choice becomes likely, repeated, and difficult to exit. Addictive commodities are precisely the case where structural agency matters because dependence and marketing amplify small initial decisions into long-term behavioral lock-in.

Firms bear a distinctive responsibility because they are not merely responding to demand; they are professionally engaged in demand creation and retention. When a company invests in brand identity, distribution saturation, and promotional strategies, it is not passively meeting a preference. It is engineering the social and psychological conditions of uptake. For a lethal addictive product, that places the firm closer to the moral center of the harm pathway than "ordinary commerce" would suggest.

States bear responsibility in two roles: as protectors of their citizens and as wielders of external pressure. A state that uses trade tools to expand the overseas market for a lethal commodity participates in the structural agency of harm, even if it does not manufacture the product. The responsibility here is not identical to the firm's, but it is real: applying sovereign power to narrow another sovereign's health-protective options is an act with foreseeable consequences.

Target-country regulators and governments also bear responsibility, but the moral weight depends on their real policy space. If the regulatory environment is constrained by external leverage, institutional capacity, or political capture, then "they could have regulated more" becomes less a moral refutation than a description of tragedy: the burden is placed on the weaker party to resist pressures it cannot fully resist. Shared responsibility must not become a license for the powerful to deny their share.

Finally, there is a category of responsibility that is often neglected: responsibility for foreseeable cohort effects. If policies predictably increase youth initiation—even indirectly through marketing permissions or price competition—then the harm is not merely an aggregation of adult choices. It includes the systematic recruitment of future dependence among those least equipped to evaluate long-horizon risk. Ethically, that raises the stakes because it implicates justice for the vulnerable.

5.4 The “free trade” frame vs the “public health sovereignty” frame

The moral conflict is often framed as a clash of principles.

The free trade frame treats open markets as presumptively good and restrictions as presumptively suspect. It emphasizes non-discrimination, predictable rules, and resistance to protectionism disguised as regulation. Within this frame, cigarettes are treated like any other product category: the key question is whether foreign firms face unfair barriers.

The public health sovereignty frame treats population health as a foundational responsibility of the state, and it emphasizes that some commodities are not ethically neutral. Within this frame, “market access” is not an unquestioned good when it predictably increases addiction and death. The key question becomes whether a society has the right to set its own risk environment, even if that frustrates foreign commercial ambitions.

The deepest tension is that both frames contain real values. Rules and non-discrimination can prevent arbitrary economic warfare. Public health protections can prevent mass harm and preserve human flourishing. The ethical failure occurs when one frame is allowed to swallow the other—when trade principles are treated as absolute while health is treated as negotiable.

A more disciplined approach is to treat health sovereignty as a high-order constraint: trade can be open, but not in ways that force a society to expand exposure to uniquely harmful, dependence-forming commodities against its considered judgment. This does not require blanket bans. It requires recognizing that “least trade restrictive” is not the same as “most health protective,” and that the moral legitimacy of trade pressure diminishes as the product’s lethality and dependency properties increase.

In this light, the cigarette market-opening era becomes a test case for modern governance ethics: whether procedural, legalistic coercion can be treated as morally clean when its foreseeable outcome is the enlargement of a lethal addiction pathway. The answer this paper develops is not that trade must stop, but that trade must be bounded by a principle of non-exported harm: a state should not use its power to impose increased mortality risk on other populations for commercial gain, especially when the victims are future cohorts who never consented to the bargain.

6. Counting the Dead: What Can and Cannot Be Attributed to “U.S. Cigarettes”

“How many people have died worldwide from U.S. cigarettes?” sounds like a clean empirical question, but it hides a definitional trap. Death certificates do not record “brand-of-cigarette,” many “U.S.” brands are produced under license abroad, corporate ownership changes over time, and smoking-related deaths emerge decades after exposure. What we can do responsibly

is separate (a) what is measurable from (b) what is inferable, and then specify a transparent method that produces ranges rather than a single pseudo-precise number.

6.1 The attribution problem: brand ownership, licensing, local manufacture

The phrase "U.S. cigarettes" can mean at least four different things, each yielding a different answer:

1. **U.S.-manufactured exports.** This is the narrowest definition, but it misses most real-world exposure because cigarettes are often manufactured locally for cost, freshness, taxes, and distribution reasons.
2. **U.S.-owned brands sold abroad.** This includes cases where a brand's strategic control (marketing, product design, portfolio decisions) is held by a U.S.-linked firm, even if manufacturing occurs elsewhere.
3. **Historically U.S.-origin brands now owned by non-U.S. entities.** Corporate restructuring and international spin-offs can shift ownership while the brand identity remains continuous to consumers.
4. **U.S. policy-enabled market expansion.** This treats "U.S." as the state apparatus that used trade leverage to widen access, regardless of which company ultimately sold the cigarettes.

Each definition tracks a different moral object: physical origin, corporate control, historical lineage, or policy causation. A single death cannot be unambiguously assigned to all four, and a serious accounting must declare which one it is using.

Licensing complicates attribution further. A "U.S." brand may be produced by a domestic monopoly under license, with local ingredients, local distribution, local pricing, and local advertising rules. Is that still "U.S."? From a supply-chain standpoint, no. From a brand-and-strategy standpoint, often yes. From a policy standpoint, sometimes. The ethical and empirical answer depends on what you mean by "from."

Finally, illicit trade and product substitution blur the map. Counterfeit cigarettes, smuggled cartons, roll-your-own products, and later shifts to alternative nicotine products can all distort simple "brand share → deaths" mappings. The more you zoom out globally, the more the word "attributed" must be handled with humility.

6.2 Measuring exposure: market share, consumption intensity, initiation rates

Smoking-related mortality is driven by **cumulative exposure**, not mere presence in a market. Exposure has three core components:

- **Market share over time.** A brand's share in a single year is less relevant than its share across the decades that produced today's disease burden. The relevant quantity is closer to "share of total cigarettes consumed" integrated over time.
- **Consumption intensity (pack-years).** Two markets with equal brand share can yield different harms if one market has heavier daily smoking, earlier initiation, lower quit rates, or higher cigarettes-per-day.
- **Initiation and cessation dynamics.** Because most long-run mortality is downstream of initiation (often at younger ages), a brand's role in recruiting new users can matter more than its role in "switching" existing smokers from one brand to another. The hard truth is that marketing and price competition can change cohort size, not just brand distribution.

A practical implication follows: brand attribution should not be based solely on today's sales. It should be based on **historical exposure trajectories**: who started when, how intensely they smoked, how long they smoked, and which products dominated their consumption during the decisive years of accumulation.

6.3 Translating exposure to mortality: epidemiologic risk models and lags

Smoking does not "cause" a single disease in a simple one-to-one way. It elevates risk across a spectrum: lung cancer, multiple other cancers, cardiovascular disease, stroke, COPD, and additional conditions. The standard epidemiologic move is to compute a **population attributable fraction** (PAF): the fraction of deaths from a given cause that would not have occurred in a counterfactual world with no smoking (or with lower smoking).

In its simplest form for one exposure category, the idea is:

$$PAF = p*(RR - 1) / (p*(RR - 1) + 1)$$

where p is prevalence (or exposure proportion) and RR is relative risk. Real models stratify by age, sex, intensity, duration, and sometimes time-since-cessation, then combine causes across disease categories.

The other key feature is **lag**. Today's smoking-attributable deaths largely reflect smoking behaviors from 10, 20, 30+ years ago, depending on disease. This lag breaks naive allocation. If a brand gained market share recently, it may have limited contribution to current mortality (though it may shape future mortality). Conversely, a brand that dominated decades ago can drive present deaths even if its current share is small.

Thus, translating exposure to deaths requires two alignments:

- **Temporal alignment:** match deaths in year T to exposure histories in earlier decades.
- **Causal alignment:** map exposure histories to disease risks using established relative-risk structures and cessation effects.

Any estimate that ignores lag will be systematically biased, usually toward over-crediting recent market shares and under-crediting historic dominance.

6.4 A transparent estimation framework with uncertainty bounds

A responsible estimation framework should be explicit, modular, and range-based. One workable approach is:

Step 1: Choose the definition of "U.S. cigarettes."
State it plainly: U.S.-manufactured exports, U.S.-owned brands, historically U.S.-origin brands, or policy-enabled expansion. If needed, run multiple definitions as separate scenarios.

Step 2: Define the geography and time window.
Global is possible, but regional analyses can be more credible (because data quality varies and illicit trade shares vary). Specify the outcome window (e.g., deaths in 2000–2025) and the exposure window (e.g., smoking histories 1970–2015).

Step 3: Reconstruct exposure by cohort.
Estimate smoking prevalence and intensity by age/sex cohort over time, and estimate brand shares over the same period. The key constructed metric is "brand-attributable pack-years" (a weighted share of cumulative exposure, not a single-year sales snapshot).

Step 4: Estimate smoking-attributable deaths (all brands combined).
Use an accepted comparative-risk framework to estimate total smoking-attributable mortality by cause and demographic group, incorporating cessation where possible.

Step 5: Allocate attributable deaths across brands (or brand families).
Allocate proportional to cumulative exposure measures with lag weights. This is the most assumption-sensitive step, and it must be presented as such. At minimum, provide three allocations: (a) proportional to historical cigarette volume, (b) proportional to estimated pack-years, (c) proportional to pack-years with stronger weights for early initiation years.

Step 6: Quantify uncertainty and show ranges.
Attach uncertainty to each module: prevalence, intensity, brand share histories, lag structure, and relative risks. Use scenario bands or Monte Carlo propagation. Report outputs as ranges (e.g., 5th–95th percentile) and include sensitivity analysis showing which assumptions drive the spread.

Step 7: Publish the assumptions, not just the results.
The ethical goal is auditability: readers should be able to see exactly which choices produce which numbers.

This framework does not magically solve the attribution problem, but it prevents the worst failure mode: a single impressive-looking number that cannot be defended when definitions shift.

6.5 Ethical use of numbers: avoiding propaganda and false precision

Counting the dead is morally necessary and morally dangerous.

It is necessary because harm that cannot be measured is easily denied, and delayed mortality is especially prone to institutional amnesia. But it is dangerous because numbers can become weapons: used to assign total guilt to one actor, to absolve another, or to inflame rather than clarify.

A few discipline rules help:

- **Separate statistical attribution from legal or personal blame.** "Attributable" in epidemiology means "would not have occurred in a counterfactual." It is not identical to proving causation in a particular person's case.
- **Never hide definitional choices.** "U.S. cigarettes" must be defined up front, and alternative definitions should be shown when they materially change conclusions.
- **Prefer ranges to point estimates.** A single number invites false certainty and rhetorical overreach. Ranges communicate both scale and humility.
- **Do not moralize the arithmetic.** The moral argument should be carried by the structure (foreseeability, leverage, externalization), not by rounding tricks.
- **Avoid presentist traps while refusing moral laundering.** It is fair to ask what was known at the time and what policy space existed. It is not fair to treat "everyone was doing it" or "it was legal" as a full ethical defense when the harm was foreseeable.

Used well, numbers do not end the argument; they discipline it. They force the conversation to move from slogans ("millions died") to accountable claims ("under this definition, using these exposure histories and these risk models, the range is X to Y, and these assumptions matter most"). That is the only way to discuss externalized mortality without turning tragedy into propaganda.

7. Law and Governance: Health Exceptions, Non-Discrimination, and Policy Space

The modern tobacco "market opening" conflicts did not occur in a vacuum. They unfolded inside a legal architecture built to reduce arbitrary discrimination in trade while still permitting states to govern for health, safety, and public order. That architecture has a characteristic moral tension: it is designed to prevent protectionism disguised as regulation, yet it can also pressure governments to defend their health measures in a courtroom-like setting where economic burdens are concrete and health benefits are probabilistic, long-term, and hard to attribute. Understanding the law-and-governance layer clarifies how coercion can be procedural rather than military, and how public health can be permitted in principle yet constrained in practice.

7.1 Trade law basics: the logic of retaliation and compliance

Trade regimes work because they translate political conflict into repeatable procedures. The basic bargain is: states accept constraints on certain forms of discrimination and market closure, and in return they gain predictability and access. The enforcement mechanism is not police power in the usual sense; it is reciprocal pressure.

In most modern trade systems, the logic runs as follows. A state alleges that another state's measure violates commitments (for example, by discriminating against imports or by imposing barriers not justified under the rules). The parties consult. If consultation fails, the dispute can proceed to adjudication. If the challenged measure is found inconsistent, the losing party is expected to bring its measure into compliance. If it does not, the winning party may be authorized (formally or informally, depending on the system) to retaliate by suspending concessions, often through tariffs on selected exports.

This structure creates a distinctive kind of leverage. Retaliation can be targeted where it hurts politically rather than where the violation occurred substantively. That gives the complaining state a way to make a health regulation in one sector costly to unrelated industries in the regulating state. The result is a governance incentive: even if the health measure is defensible, the state may prefer to settle or soften it to avoid broader economic pain.

Retaliation also produces a compliance dynamic that is partly performative. Governments are pressed to show they are "rule-following" members of an economic order. This reputational pressure can matter even when the economic stakes are moderate. In tobacco disputes, that pressure can interact uneasily with domestic health ministries, which may see the same measures as necessary, not negotiable.

7.2 Health protections under trade regimes: what is permitted, what is contested

Most trade regimes do not say, "You may not protect public health." They say, in effect, "You may protect health, but you must do so without unjustifiable discrimination, and you must

justify the measure with reasons and evidence that fit the rule structure." The friction lives in that "but."

Two core principles drive the contest.

First is non-discrimination. In trade law terms, this usually means treating like products alike, regardless of origin. A regulation that bans foreign cigarettes but permits domestic cigarettes is the clearest violation. Less obvious are regulations that are formally origin-neutral but functionally protectionist, such as rules that domestic producers can meet easily while foreign producers cannot, without a health rationale that explains the asymmetry.

Second is proportionality or necessity logic (the exact doctrinal form varies by agreement). The recurring question is whether the measure is more trade-restrictive than needed to achieve the health objective, given reasonably available alternatives. A state can often regulate strongly, but it may be asked to explain why it chose one instrument (for example, an import ban) instead of another (for example, a non-discriminatory tax, ingredient disclosure, licensing, warning labels, advertising restrictions, or restrictions on sale to minors).

This is where "policy space" becomes real. In principle, a government can pursue health goals. In practice, it may be pushed toward a subset of policy instruments that satisfy trade tests more easily. Measures that apply equally to domestic and imported products tend to be more defensible. Measures that target the border (bans, quotas, import licensing used as de facto prohibition) are more likely to be contested unless the state can show they are genuinely necessary and that less trade-restrictive measures cannot achieve comparable health protection.

A further complication is the evidentiary burden. Health protection is often preventive. It involves probabilities, long horizons, and population-level benefits. Trade tribunals and trade negotiators tend to prefer visible logic: measurable discrimination, measurable burdens, and clear causal links. This structural mismatch can place health regulators in the position of "proving" prevention, which is always harder than proving damage after the fact.

7.3 The advertising question: commercial speech vs population health

Advertising sits at the intersection of trade, constitutional law, and public health. It is not merely a marketing channel; it is the social machinery of initiation and normalization. That makes it one of the most contested domains.

In some legal cultures, commercial speech is treated as strongly protected, and restrictions must be narrowly tailored. In other cultures, advertising is treated as a regulable commercial practice, especially for harmful products. The governance result is uneven: the same public health

rationale can produce very different legal outcomes depending on constitutional doctrine and judicial tradition.

From a trade perspective, advertising restrictions generate three recurring disputes.

First, whether the restriction is discriminatory. A rule that restricts advertising for imported brands more than domestic brands is vulnerable. A rule that restricts advertising for all cigarettes can be easier to defend, but it can still be challenged if it is framed as an unnecessary barrier or if it collides with commitments about services, intellectual property usage, or market access for distribution.

Second, whether the restriction is proportionate to the health objective. Comprehensive advertising bans are often justified on the ground that partial bans are porous and simply shift marketing to permitted channels. Opponents often argue that narrower measures could achieve the goal with less restriction on commercial expression.

Third, whether packaging and branding controls are "advertising by another name." Plain packaging, large graphic warnings, limits on descriptors, and standardized appearance reduce the brand's ability to function as identity signaling. From a health perspective, that is the point. From an industry perspective, it can be framed as interference with trademarks and brand value. Trade and investment arguments then attempt to translate a public health measure into a property-rights dispute.

What emerges is a key governance insight: for tobacco, the most effective demand-reduction tools often operate through informational and identity channels, not only through prices. Those tools can be legally contestable because they directly restrict the commercial machinery that turns nicotine delivery into culture.

7.4 The long arc: global tobacco control norms and treaty approaches

Over time, tobacco governance developed an international normative backbone: the idea that tobacco is not an ordinary consumer good and therefore warrants coordinated public health action. That shift matters for policy space because it changes what counts as "reasonable" regulation. A country defending strong measures can point to global best practices and treaty-aligned frameworks as evidence that its approach is mainstream public health, not disguised protectionism.

Treaty approaches also matter because they create a counterweight to trade pressure. When health ministries can say, "We are implementing internationally endorsed measures," they gain political legitimacy at home and a stronger narrative abroad. The long arc is a move from isolated national regulation toward a shared template: higher excise taxes, smoke-free spaces,

prominent warnings, restrictions on marketing, measures against illicit trade, and institutional separation between tobacco industry influence and health policy.

Yet the arc does not eliminate tension. Trade and investment systems are designed to protect predictability for commerce; tobacco control is designed to reduce consumption of a legal product. The friction persists, but it changes character. Instead of arguing whether health regulation is permitted at all, the argument shifts to how it must be designed: origin-neutral, evidence-based, internally coherent, and connected to a recognized public health rationale.

In that sense, the governance lesson is not that law forbids health protection. The lesson is that law shapes which forms of protection are easiest to defend, and it rewards regulators who build measures that are both strong and rule-literate. The policy space exists, but it is not free. It must be engineered.

8. Lessons and Contemporary Echoes

If we treat "opium wars" as a moral fable, we learn almost nothing—only that the past was brutal and the present is refined. If we treat it as a structural baseline, we learn something harder: systems can export harm through commerce when power is asymmetric, and the harm can be normalized through the language of rules. The cigarette market-opening episodes do not reproduce the opium story's illegality or overt imperial violence, but they do reproduce something that is ethically central: the use of state leverage to reshape another society's exposure to an addictive commodity with mass mortality implications.

This section extracts lessons that are usable, not rhetorical. It identifies where the analogy is strongest, where it breaks, and how to build governance guardrails so that future trade power does not quietly become a technology for exporting preventable death.

8.1 The strongest analogies and the decisive differences

The strongest analogies are not about substances; they are about mechanisms.

The first strong analogy is **power applied to policy space**. In both cases, a stronger external actor sought to expand access for a profitable addictive commodity, and the target society sought, to varying degrees, to restrict it. The conflict centered on whether the target could set its own risk boundary. When the stronger actor's interests prevailed, the target's autonomy was narrowed.

The second strong analogy is **the conversion of commerce into principle**. In the opium era, the language was often civilizational and honor-bound: trade as progress, restriction as backwardness. In the cigarette era, the language became procedural: non-discrimination,

market access, rules compliance. Different vocabulary, same move: a particular commercial objective is universalized into a moral or legal necessity.

The third strong analogy is **externalized, delayed harm**. Opium and tobacco both generate costs that unfold across years: addiction, family disruption, health decline, fiscal burden. The exporter can cash benefits quickly; the importer pays slowly. The time lag is not incidental. It is the enabling condition for plausible deniability and for institutional amnesia.

But the differences matter, and they matter precisely because they shape what prevention can look like.

The decisive difference is **legality and governance form**. Opium in Qing China operated through smuggling and prohibition dynamics; the disputes escalated into armed conflict and imposed treaties. Cigarettes were legal consumer goods; the coercion was mediated through trade law tools, negotiations, and adjudication. This difference matters because it changes what "resistance" looks like. In the modern case, the target can build non-discriminatory internal regulation that survives trade scrutiny; in the opium baseline, internal regulation collided with foreign force in a more direct way.

Another decisive difference is **institutional pluralism**. Modern states operate with health ministries, civil society, epidemiology, treaties, and global norms that did not exist in the same form in the 19th century. That institutional ecosystem makes it possible to resist harm expansion through coordinated policy rather than through crude border closure alone.

A final difference is **the moral clarity of intent**. The opium story is often narrated as deliberate poisoning for profit. The cigarette case is more complicated: trade officials may have framed their actions as neutral enforcement of trade principles, even while the harms were foreseeable. Ethical responsibility does not disappear with mixed motives, but the governance diagnosis becomes more subtle: the system can generate harm exporting even when no individual actor declares that as a goal.

8.2 When "market opening" becomes "harm exporting"

"Market opening" becomes "harm exporting" when four conditions converge.

First, the product is not merely risky but **inherently harmful at scale when used as intended**. Tobacco is not unsafe because of misuse; it is unsafe because normal use is lethal for many long-term users.

Second, the product is **dependency-forming**, so that uptake is sticky and cessation is difficult. Dependency converts small changes in access into large changes in long-run harm.

Third, the market-opening action **predictably expands uptake** rather than merely reallocating brand shares among existing users. This is where marketing permissions, retail saturation, and price competition matter. If opening a market increases initiation—especially youth initiation—then the policy has created new future casualties, not simply moved revenue between firms.

Fourth, the exporting actor **captures benefit while the importing society bears the downstream burden**. The outward flow of profits (or the inward flow of trade advantages) combined with local health costs is what makes the mortality "externalized."

Under these conditions, market opening is no longer ethically neutral. It becomes a transfer of risk. In moral terms, it resembles dumping—except what is dumped is not waste, but a higher probability of chronic disease and premature death distributed across millions of bodies.

This framing also clarifies a common confusion: "But the country could regulate." Sometimes it can, sometimes it cannot, and sometimes the pressure applied was precisely designed to narrow the menu of regulatory options. Harm exporting does not require total incapacity in the target state; it requires that external leverage shifts the balance in favor of expanded exposure.

8.3 Institutional safeguards: how to prevent coercive expansion of lethal commodities

If the pattern exists, the policy question is: what safeguards would prevent it from recurring, especially in "clean" procedural forms that avoid scandal?

One safeguard is **health-first carveouts that are explicit and robust**. Trade systems already allow health measures in principle, but the practical test often becomes contested. Stronger safeguard design would treat certain classes of commodities—those with extreme attributable mortality and dependence—as requiring a presumption in favor of health regulation, as long as measures are non-discriminatory and evidence-based.

A second safeguard is **firewalls between trade advocacy and lethal-commodity promotion**. Governments often promote exports. But export promotion should not automatically extend to goods with extraordinary harm profiles. A simple governance reform is to require an internal review (health impact assessment) before trade agencies support market-opening demands for such products, with mandatory documentation and public justification.

A third safeguard is **anti-capture protocols**. In many policy domains, industry influence is a known risk. For tobacco and analogous goods, institutional rules that limit industry participation in health policymaking and that require transparency in lobbying and negotiations reduce the probability that commercial goals will be smuggled into "neutral" policy.

A fourth safeguard is **non-discriminatory internal policy templates ready to deploy**. Countries are most vulnerable to trade pressure when their only defenses are border controls (bans, quotas) that are easily framed as discriminatory. If states have ready-to-implement internal

measures—taxation, advertising restrictions that apply equally, retail licensing, age enforcement, packaging rules, smoke-free laws—they can protect health while reducing vulnerability to trade challenges.

A fifth safeguard is **long-horizon accountability**. The time lag that hides mortality can be countered by institutions that force long-horizon accounting: projected attributable deaths, projected healthcare costs, and cohort impacts as part of the decision record. When governments must sign their names to the projected consequences, procedural coercion becomes less morally invisible.

8.4 A compact test for future cases: product lethality, dependency, leverage, sovereignty

To keep this paper usable beyond tobacco, we need a compact test: a diagnostic that can be applied to future disputes without turning every trade conflict into a moral panic. The test is four-part.

Product lethality. Does ordinary use, at population scale, produce high attributable mortality or severe chronic disease burden? If the harm is marginal or rare, the ethical stakes differ. If the harm is massive and well established, the stakes rise sharply.

Dependency. Does the product create dependence that undermines the consumer's future freedom to stop? Dependency includes pharmacological addiction, but also behavioral and social reinforcement. The stronger the dependency, the more ethically charged it is to expand access.

Leverage. Is the market opening achieved through symmetric negotiation or through asymmetric coercion (retaliation threats, sanctions, linked-sector punishment)? The more the target's consent is shaped by credible threat, the more the outcome resembles coercion rather than mutual agreement.

Sovereignty. Does the external pressure narrow the target society's legitimate ability to set its own health risk boundaries? This is not a claim that sovereignty is absolute. It is a claim that health-protective governance is among the most legitimate uses of state power, and that coercive interference with it demands exceptional justification.

When all four conditions score high—high lethality, strong dependency, strong leverage, and meaningful sovereignty displacement—the pattern we have studied is likely present. At that point, "market opening" should be treated as a potential form of harm exporting, and governance systems should trigger heightened scrutiny, stronger procedural safeguards, and a presumption in favor of health policy space.

The contemporary echo, then, is not merely that "history repeats." The echo is that power finds new legal forms. The moral task is to ensure that those forms do not launder lethal outcomes

into technical victories—and to build institutions that can recognize harm exporting while there is still time to prevent the deaths that otherwise arrive later, quietly, as background.

9. Conclusion

This paper set out to do something modest but necessary: to take a historical scandal that is easy to condemn (Britain and opium in Qing China) and use it as a structural lens to examine a modern case that is easier to rationalize (trade pressure to open cigarette markets). The goal was not to collapse differences, but to make visible a recurring governance pattern that can hide inside the language of "market access" and "rules." When the commodity is addictive and lethal at population scale, trade policy is never merely trade. It is a decision about how risk is distributed across borders, cohorts, and lifetimes.

9.1 Restating the thesis: the pattern that persists after the particulars change

The thesis can now be restated with precision: a persistent pattern emerges when a powerful actor uses trade leverage to expand another society's exposure to an addictive commodity whose ordinary use produces mass morbidity and mortality. The particulars change—opium vs cigarettes; smuggling vs legal sales; gunboats vs Section 301; imperial treaty ports vs procedural compliance—but the underlying causal architecture can remain intact.

That architecture has several stable elements:

- **Incentive alignment toward expansion.** Addictive goods promise unusually stable demand and high margins, making them attractive targets for export growth when domestic markets saturate or decline.
- **Asymmetric leverage over policy space.** The stronger party can raise the cost of refusal, shrinking the weaker party's ability to set or enforce its preferred risk boundary.
- **Commercial normalization through universal principles.** The exporter's specific interest is translated into a general claim—free trade, non-discrimination, rules-based order—while the target's health-based resistance is reframed as irrationality or disguised protectionism.
- **Externalized and delayed harm.** Benefits are realized quickly (sales, revenue, political wins), while harms arrive later (disease, fiscal burden, deaths), often dispersed and therefore difficult to assign.

The crucial point is that the pattern does not require malicious intent to operate. A system can produce harm exporting as an emergent output of institutional roles: trade agencies pursue access, firms pursue market share, regulators struggle under constraint, and mortality arrives

decades later as an actuarial residue. That is precisely why the pattern is ethically dangerous: it can be executed without anyone feeling like they personally chose death.

9.2 What a responsible trade policy would require

A responsible trade policy does not mean abandoning trade, nor does it mean insulating every domestic regulation from scrutiny. It means building a bounded system that can recognize when "market access" is effectively a demand-expansion project for lethal dependence—and that refuses to apply coercive leverage in those cases.

Several requirements follow.

First, **categorical seriousness about product class**. Not all goods are equal in moral risk. A trade system that treats cigarettes like soybeans will eventually externalize mortality as an administrative side effect. Responsible policy must acknowledge that certain commodities—high attributable mortality, dependence-forming, youth-recruiting—deserve heightened constraints on export promotion and market-opening demands.

Second, **health-impact accountability inside trade institutions**. When trade agencies seek concessions for harmful addictive products, they should be required to produce explicit health impact assessments, including long-horizon estimates and uncertainty bands. The procedural record should show that future deaths were considered, not ignored. This is not about perfect forecasting; it is about moral visibility.

Third, **a presumption for non-discriminatory internal regulation**. If a state aims to protect public health, trade regimes should steer disputes away from "you must allow the product" and toward "design your protections so they apply equally." This preserves the core anti-protectionist function of trade law while protecting policy space for strong health measures that do not discriminate by origin.

Fourth, **limits on coercive linkage**. The most ethically troubling leverage is cross-sector retaliation used to force health concessions: punishing unrelated exporters to pressure a government into relaxing controls on a lethal commodity. Responsible policy would restrict or forbid that kind of linkage for certain product categories, precisely because it bypasses democratic deliberation about health.

Fifth, **institutional firewalls against capture**. Where products are lethal and dependence-forming, the risk of policy capture rises. Responsible governance requires transparency in lobbying, separation between industry influence and health policy design, and safeguards that prevent the commercial actor from writing the rules under the banner of "trade compliance."

Finally, **long-horizon moral symmetry**. A state should not ask another society to accept exposure that it has already judged too dangerous to tolerate at home. Domestic health policy

and external trade posture should not be mirror opposites. Where the state discourages consumption domestically through warnings, restrictions, and campaigns, it should not use coercive instruments to expand consumption abroad. If it does, it must justify that contradiction openly—and such justification will rarely be morally convincing.

These requirements do not eliminate conflict. They clarify which conflicts should not be waged with the full force of state leverage.

9.3 Closing reflection: commerce as power, and power as moral choice

Commerce is often narrated as if it were nature: flows, markets, preferences, inevitabilities. But the cases examined here show that commerce is frequently power in procedural clothing. Ports can be opened by treaties; markets can be opened by sanctions threats; advertising can be opened by legal concessions; regulatory space can be narrowed by "compliance." None of this is automatic. It is chosen.

The moral challenge of modernity is that choices can be made in technical language that disguises their human consequences. "Non-discrimination" can be used to defend fairness; it can also be used to pry open a society's defenses against a lethal commodity. "Market access" can mean honest competition; it can also mean engineered recruitment into addiction. "Rules-based order" can mean restraint; it can also mean the institutionalization of asymmetry.

The disciplined stance is not anti-trade. It is anti-laundering: refusing to let procedure cleanse outcomes. When a state uses its leverage to expand access to a dependence-forming lethal product, it is not merely negotiating tariffs. It is shaping who will suffer and who will profit, who will be sick later and who will be paid now. The deaths may not be immediate, and they may not be branded, and they may not be traceable to a single decision-maker. But they are not morally random.

In the end, the comparison between opium and cigarettes is not a claim that history repeats in costume. It is a claim that power learns. When cannons become costly and reputationally toxic, power migrates into policy instruments. That migration makes moral vigilance more difficult, not less necessary. Commerce is a tool. State leverage is a tool. Tools do not decide what they are used for. People and institutions do. And that is why this subject remains, finally, a question of conscience: what kinds of profits we will defend, what kinds of harms we will permit, and what kind of world we are willing to build while telling ourselves we are merely "doing trade."

Epilogue: A Numerical Estimate of Deaths From "U.S. Cigarettes" Worldwide

E.1 What I mean by "U.S. cigarettes" in this estimate

I am not counting "made in the USA" sticks. I am counting the global death burden attributable to cigarettes sold under the big U.S.-origin brand families that were pushed (directly or indirectly) by U.S. commercial power in the late-20th-century "market opening" era. In practice, the dominant "U.S.-origin" portfolio in the international cigarette trade is Philip Morris's cigarette business (especially Marlboro), even though the corporate structure later changed.

E.2 What we can actually measure

No dataset tags a lung cancer death as "this brand did it." What we can measure are (a) total cigarette-attributable deaths, (b) the approximate share of global cigarette consumption controlled by the relevant "U.S.-origin" firms/brands, and then (c) apply that share to the death totals as an attribution fraction.

E.3 Inputs (rounded)

1. Global cigarette-attributable deaths (direct smoking):

- In 2000: about 4.83 million deaths attributable to smoking.
- In 2019: about 7.69 million deaths attributable to smoking tobacco use.
- Today: on the order of 7+ million per year from tobacco overall, with cigarettes the dominant driver.

2. "U.S.-origin" share of the global cigarette market (order-of-magnitude):

- China is so large that it must be separated: roughly 47% of global tobacco sales.
- Philip Morris's cigarette share is about 25% of the international cigarette market excluding China (and excluding the U.S. in the way PMI reports it).
  A reasonable "global" translation of that is: 0.25 * (non-China share) = 0.25 * 0.53 ≈ 0.13, i.e., about 13% of the *world* cigarette market, plus/minus a bit depending on how you treat the U.S. domestic market and licensing/manufacturing structures. I will use 14% as a central estimate, with a plausible band of 10% to 18%.

E.4 The arithmetic (transparent back-of-the-envelope)

Step 1: Approximate cumulative global smoking deaths since 2000.

- From 2000 to 2019, interpolate linearly between 4.83M and 7.69M per year: average ≈ (4.83 + 7.69)/2 = 6.26M per year over ~20 years -> about 125M deaths.

- From 2020 to 2024, use ~7.0M per year as a conservative round number -> about 35M deaths.
  So, 2000–2024 cumulative direct-smoking deaths ≈ 160M worldwide.

Step 2: Attribute a fraction to "U.S.-origin" cigarette brands.

- Central: 14% of 160M ≈ 22M deaths (2000–2024).

Step 3: Extend the window back to match the trade-policy story's lag.
The big "opening" actions are late 1980s–1990s, but cigarette mortality peaks decades after uptake. If you add a conservative 1990s contribution (when global smoking deaths were already in the millions annually), you land in the ballpark of another few million attributable deaths. That pushes a central "1990 to present" estimate toward the mid-20-millions.

E.5 A single-number estimate, plus an honest uncertainty range
If you force a single headline number that matches the scope of this paper (late-20th-century market expansion with long mortality lags), a defensible estimate is:

- About 25 million deaths worldwide to date attributable to "U.S.-origin" cigarette brands (roughly 1990–2024/25).
- Plausible range: 15 million to 40 million, depending mainly on (a) what you count as "U.S. cigarettes," (b) whether you include secondhand smoke explicitly, and (c) what market-share fraction you assign over time.

A useful companion number (because it keeps you honest about scale):

- Current annual deaths attributable to "U.S.-origin" cigarette brands are on the order of about 1 million per year worldwide (very roughly 0.8M to 1.4M), using today's global tobacco death totals and a 10%–18% attribution share.

References

Historical sources on the opium trade and Opium Wars

- Fay, Peter Ward. *The Opium War, 1840–1842*. Chapel Hill: University of North Carolina Press, 1975. World Health Organization+1
- Lovell, Julia. *The Opium War: Drugs, Dreams and the Making of China*. London: Picador, 2011. American Journal of Public Health+1
- Platt, Stephen R. *Imperial Twilight: The Opium War and the End of China's Last Golden Age*. New York: Knopf, 2018. Cancer Control & Population Sciences
- Chang, Hsin-pao. *Commissioner Lin and the Opium War*. Cambridge, MA: Harvard University Press, 1964. Cambridge University Press & Assessment+1
- Fairbank, John King. *Trade and Diplomacy on the China Coast: The Opening of the Treaty Ports, 1842–1854*. Cambridge, MA: Harvard University Press, 1953. Internet Archive
- Spence, Jonathan D. *The Search for Modern China*. New York: W. W. Norton (multiple editions). PMC
- Lin, Zexu. "Letter to Queen Victoria" (1839) (in widely reprinted English translation). Global Health Data Exchange
- *Treaty of Nanking* (Nanjing), 1842 (treaty text; key provisions: indemnities, cession of Hong Kong, treaty ports). World Health Organization
- Farooqi, Amar. *Smuggling as Subversion: Colonialism, Indian Merchants, and the Politics of Opium, 1790–1843*. Lanham, MD: Lexington Books, 2005. PMC+1
- Trocki, Carl A. *Opium and Empire: Chinese Society in Colonial Singapore, 1800–1910*. Ithaca, NY: Cornell University Press, 1990. jstor.org+1
- Dikötter, Frank, Lars Laamann, and Zhou Xun. *Narcotic Culture: A History of Drugs in China*. Chicago: University of Chicago Press, 2004. University of Chicago Press+1

U.S. trade law materials and Section 301 documentation

- United States. *Trade Act of 1974* (Public Law 93–618), as amended (compiled text). GovInfo
- United States Code. 19 U.S.C. § 2411 (Section 301 authorities within the Trade Act framework). Legal Information Institute+1

- Congressional Research Service. *Section 301 of the Trade Act of 1974* (CRS In Focus; updated versions). Congress.gov+1
- U.S. Government Accountability Office. *Trade and Health Issues: Dichotomy Between U.S. Tobacco Export Policy and Antismoking Initiatives* (GAO/NSIAD-90-190). May 1990. Justia GAO Reports+1
- U.S. Government Accountability Office. *Advertising and Promoting U.S. Cigarettes in Selected Asian Countries* (GAO/GGD-93-38). 1993. U.S. GAO
- Jones, Francis H. "U.S. Tobacco Goes Abroad: Section 301 of the 1974 Trade Act." *North Carolina Journal of International Law* (1989). UNC Law Scholarship Repository
- Office of the United States Trade Representative. Section 301 enforcement overview and investigations portal (for institutional framing and modern continuity). United States Trade Representative

Case-specific records: Japan, South Korea, Taiwan, Thailand

- Chaloupka, Frank J., and Adit Laixuthai. *U.S. Trade Policy and Cigarette Smoking in Asia*. NBER Working Paper No. 5543, 1996. NBER
- Chen, T. T., and A. E. Winder. "The Opium Wars Revisited as US Forces Tobacco Exports in Asia." *American Journal of Public Health* 80, no. 6 (1990): 659–662. American Journal of Public Health+1
- Lambert, A. "How Philip Morris Unlocked the Japanese Cigarette Market." *Tobacco Control* (2004). PMC
- MacKenzie, R., C. Collin, and colleagues. "The US Trade Representative, Tobacco Companies and Market Liberalization in Thailand." *Tobacco Control* (2012). PubMed+1
- GATT Panel Report. *Thailand—Restrictions on Importation of and Internal Taxes on Cigarettes* (DS10/R), adopted 7 November 1990 (BISD 37S/200). World Trade Organization+2OUP Law+2
- U.S. Government Accountability Office. *Trade and Health Issues: Dichotomy Between U.S. Tobacco Export Policy and Antismoking Initiatives* (GAO/NSIAD-90-190). May 1990 (details on Japan/Korea/Taiwan/Thailand episodes and U.S. government roles). Justia GAO Reports+1
- U.S. Government Accountability Office. *Advertising and Promoting U.S. Cigarettes in Selected Asian Countries* (GAO/GGD-93-38). 1993 (country snapshots; promotion and marketing channels). U.S. GAO

Epidemiology and global burden of tobacco

- World Health Organization. “Tobacco” (fact sheet; periodically updated; headline global mortality figures and secondhand-smoke burden). PMC
- GBD 2019 Tobacco Collaborators (including Reitsma and coauthors). Major global estimates of smoking prevalence and attributable burden, 1990–2019 (peer-reviewed synthesis; commonly cited 2019 death totals). American Journal of Public Health
- Ezzati, Majid, and Alan D. Lopez. Global and comparative estimates of mortality attributable to smoking (landmark early-2000s synthesis; risk-attribution methods). Cancer Control & Population Sciences
- World Health Organization. *WHO Report on the Global Tobacco Epidemic* (MPOWER series; policy implementation tracking; latest available edition). World Health Organization
- U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. 2014. American Journal of Public Health
- Institute for Health Metrics and Evaluation (IHME). Global Burden of Disease study documentation and methods materials for risk attribution and uncertainty intervals (technical background for estimation). American Journal of Public Health

Ethics, political economy, and public health sovereignty

- Kickbusch, Ilona, Luke Allen, and Christian Franz. “The Commercial Determinants of Health.” *The Lancet Global Health* 4, no. 12 (2016): e895–e896. The Lancet+1
- Stuckler, David, and colleagues. “Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities.” *PLOS Medicine* (2012). PMC
- Moodie, Rob, and colleagues. “Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries.” *The Lancet* (2013). PubMed
- Drope, Jeffrey, and colleagues. “Evolving Norms at the Intersection of Health and Trade” (trade/health policy-space framing with tobacco case studies). *Public Health* / related venue (2014). PMC
- Barlow, Pepita, and colleagues. “A Thematic Document Analysis of Trade and Health Policy Space” (WTO challenge patterns for tobacco/food regulations). *PLOS Medicine* (2018). PLOS

- Taylor, Allyn L., and Douglas W. Bettcher. “WHO Framework Convention on Tobacco Control: A Global ‘Good’ for Public Health.” *Bulletin of the World Health Organization* (2000). PubMed+1
- Roemer, Ruth, Allyn L. Taylor, and Jean Lariviere. “Origins of the WHO Framework Convention on Tobacco Control.” *American Journal of Public Health* 95, no. 6 (2005): 936–938. PMC+1
- WTO Appellate Body Report. *United States—Measures Affecting the Production and Sale of Clove Cigarettes* (WT/DS406/AB/R), adopted 24 April 2012. World Trade Organization+1
- WTO dispute set. *Australia—Plain Packaging* panel reports circulated 28 June 2018; subsequent appellate-stage documents (as available). World Trade Organization+2United States Trade Representative+2
- Philip Morris v. Uruguay (ICSID ARB/10/7), award (2016) (investment-law intersection with tobacco regulation). World Trade Organization
- Philip Morris Asia Limited v. Australia (PCA Case No. 2012-12), Award on Jurisdiction and Admissibility (17 December 2015). PCA-CPA+1

The author has published over 4,700 AI-assisted papers at: https://www.researchgate.net/profile/Douglas-Youvan/research . Google Scholar has indexed these preprints, and if you want a particular reference, the AI mode of a Google search (Gemini) has efficiently catalogued these preprints.